TOWN OF TAPPAHANNOCK
P.O. BOX 266
915 CHURCH LANE
TAPPAHANNOCK, VA 22560
(804) 443-3336

Business/Owner Name:_____

Address:_____
_____

Use/Location of Devise:_____

Device Type:_____ Test Type:_____

Manufacturer:_____Model:_____

Serial:_____ Size:_____

Line Pressure at the Time of Test_____PSI

Existing/Replacement/New Device (circle one)

REDUCED PRESSURE ZONE DEVICE	**Requirement**	**Initial Test**	**Repairs**	**Retest**
Check Valve #1 Pressure drop across check value #1	Closed Tight min of 5.0. psid	Yes/No (circle one) psid (A)		Yes/No (circle one) psid (A)
Check Valve #2	Closed Tight	Yes/No (circle one)		Yes/No (circle one)
Differential Pressure Relief Port	Must open @min. of 2.0 psid	Opened @psid(B)		Opened @psid (B)
Pressure Buffer	A-B=3.0 psid or>	psid		psid
DOUBLE CHECK VALVE DEVICE	**Requirement**	**Initial Test**	**Repairs**	**Retest**
Check Valve #1	Closed Tight @ Min of 1.0 psid	Yes/No (circle one)		Yes/No (circle one)
Check Valve #2	Closed Tight @ Min of 1.0 psid	Yes/No (circle one)		Yes/No (circle one)
PRESSURE VACUUM BREAKER	**Requirement**	**Initial Test**	**Repairs**	**Retest**
Air Inlet	Closed @ min. of 1.0 psid	Yes/No (circle one) _____psid		Yes/No (circle one) _____psid
Check Valve	Closed @min of 1.0 psid	Yes/No (circle one) _____psid		Yes/No (circle one) _____psid

Remarks:_____

_____

Certification: I have made the above test and hereby certify that this backflow prevention device performed satisfactorily and meets all federal, state and local codes and regulations as required.

Tester Name: (Please Print)_____

Please Sign:_____ Date:_____

License #_____Expiration Date:_____ City of Certification:_____

Testing Company:_____ Phone #_____

Company Address:_____ *File: Backflow form*